

2011 Military Health System Conference

Behavioral Health in the Patient Centered Medical Home: Meeting the Quadruple Aim

Part 1

The Quadruple Aim: Working Together, Achieving Success

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January 24, 2011



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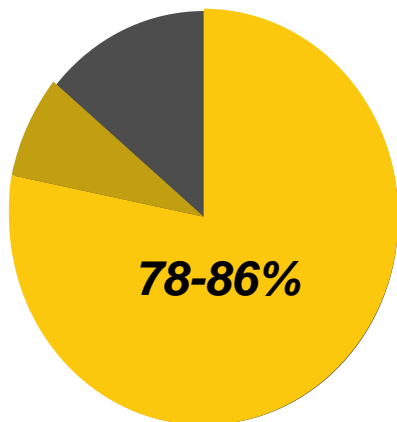
Why Primary Care?

A Gap Between Needs & Services

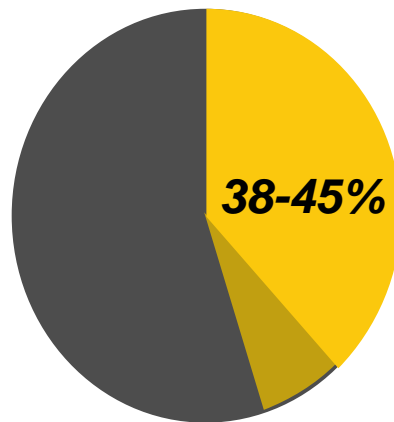
Among the 20% of Soldiers with moderate to severe disorder after OIF deployment...

Got help (past 12 months)

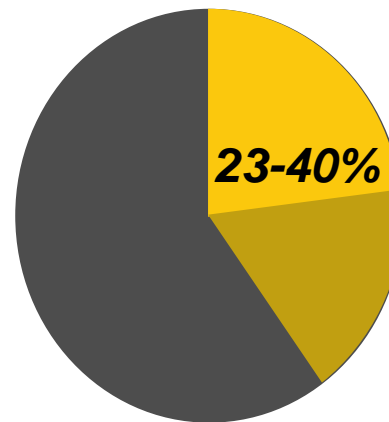
*Acknowledge
a problem*



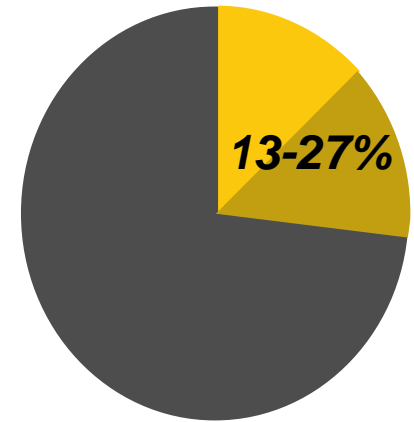
Want help



*Any
professional*



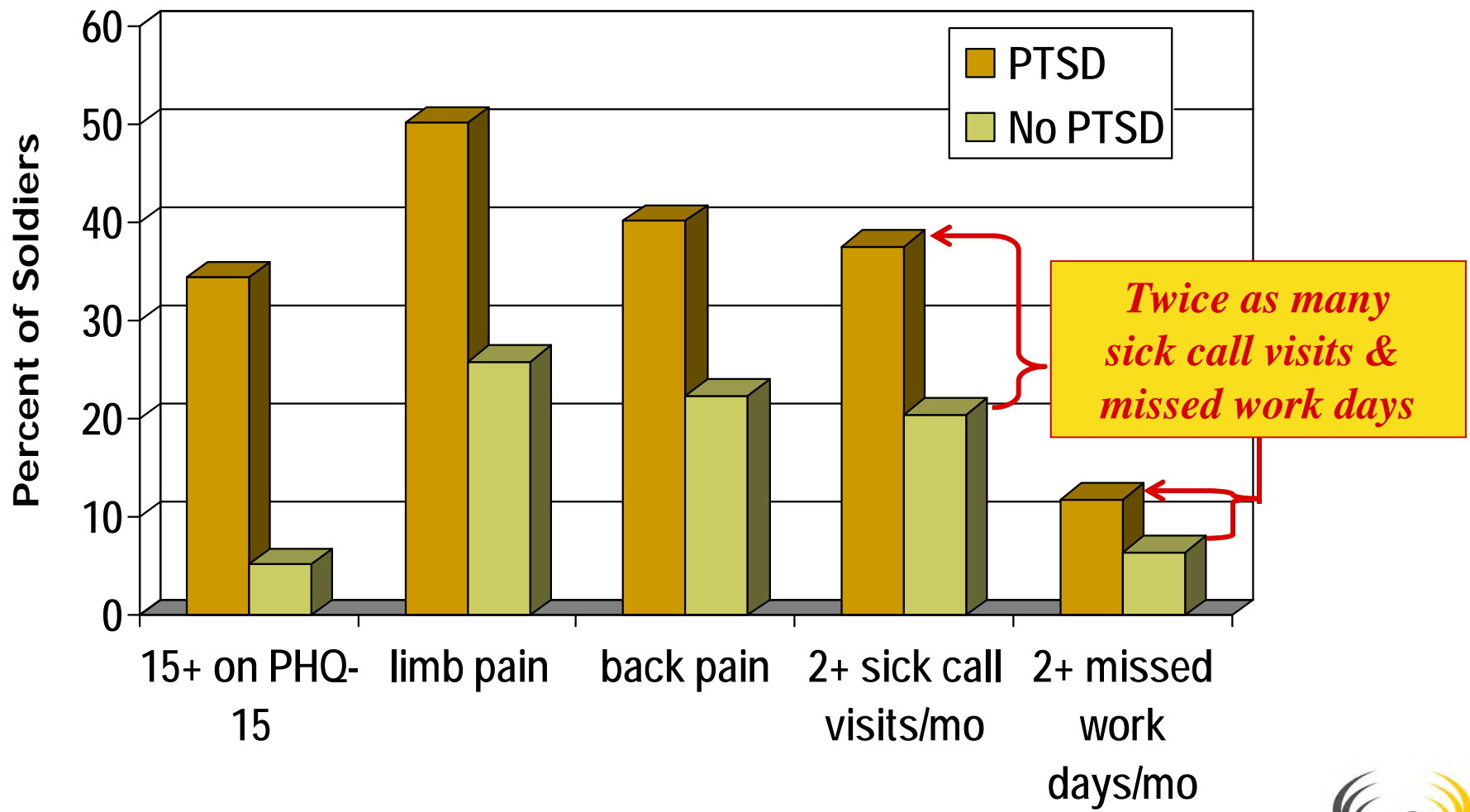
*Mental health
professional*



Hoge CW, et al. N Engl J Med. 2004;351:13-22.

Potential for Offset: Service Use & Missed Work

2,863 Iraq War returnees one-year post-deployment



Hoge et al, Am J Psychiatr, 2007

Primary Care...

Where Soldiers Get Their Care



- Mean primary care use is 3.4 visits per year
- 88-94% have one or more visits per year
- Primary care approach to mental health is an opportunity to...
 - Reduce stigma & barriers
 - Intervene early
 - Reduce unmet needs
 - Reduce unnecessary service use

Primary Care Intervention is Evidence-Based



Randomized trials offer sound evidence that systems-level approaches benefit...

- Depression (e.g., IMPACT Trial BMJ 2006)
- Suicidal ideation & depression (Bruce et al, JAMA 2004)
- Depression and physical illness (e.g., Lin et al, JAMA, 2003)
- PTSD and physical injury (Zatzick, AGP, 2004)
- Panic disorder (e.g., Roy-Byrne et al, AGP 2005)
- Somatic symptoms (e.g., Smith et al, AGP 1995)
- Health anxiety (e.g., Barsky et al, JAMA 2004)
- Substance dependence (e.g., O'Connor et al. Am J Med. 1998)
- Dementia (e.g., Callahan et al, JAMA 2006)

RESPECT-Mil

Re-Engineering Systems of Primary Care Treatment in the Military

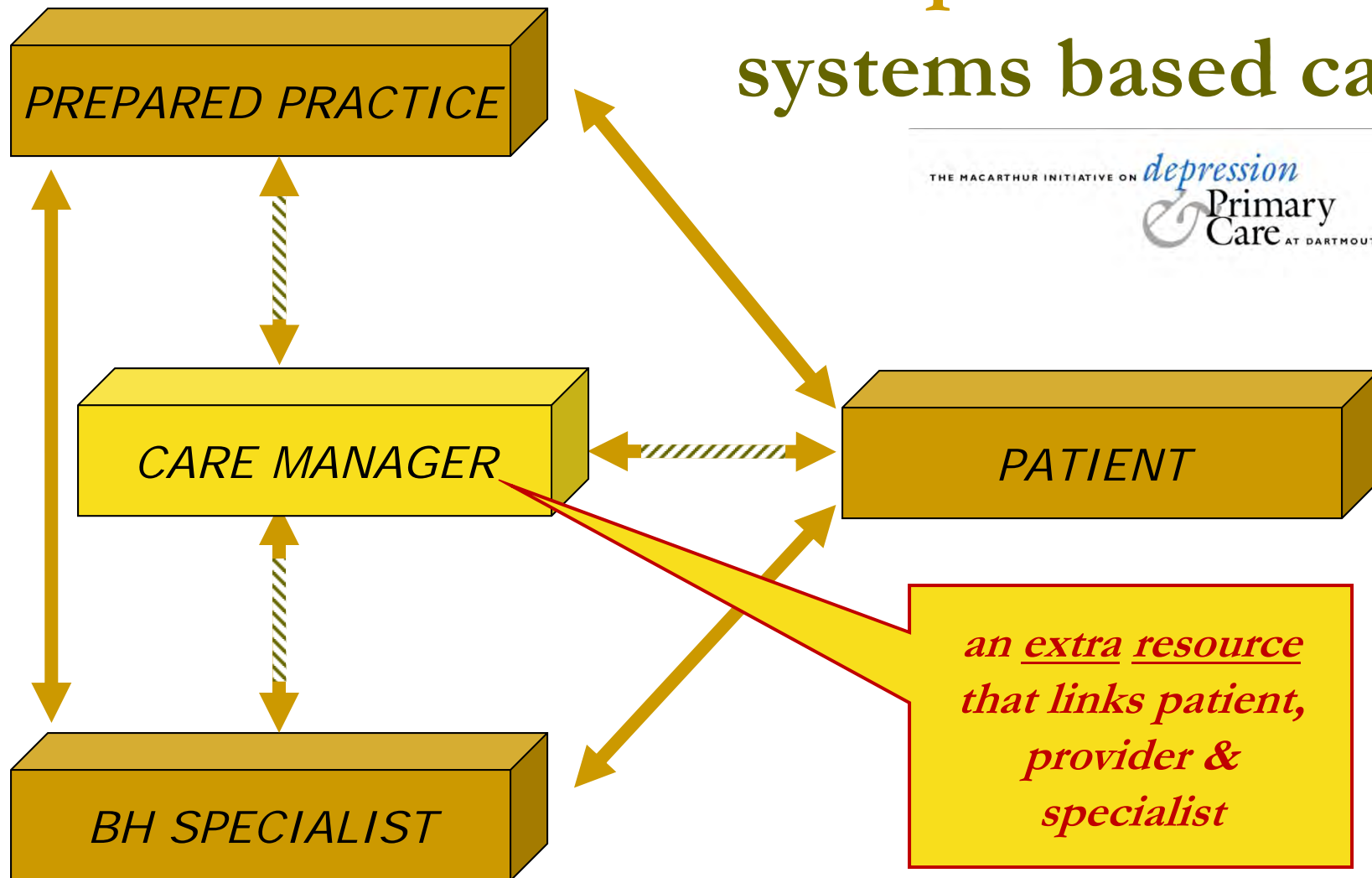
Defense Centers of Excellence for Psychological Health & TBI
Office of The Surgeon General, Army
Deployment Health Clinical Center
Uniformed Services University
3CM®

COLORADO SPRINGS, CO

5-7 OCTOBER 2010



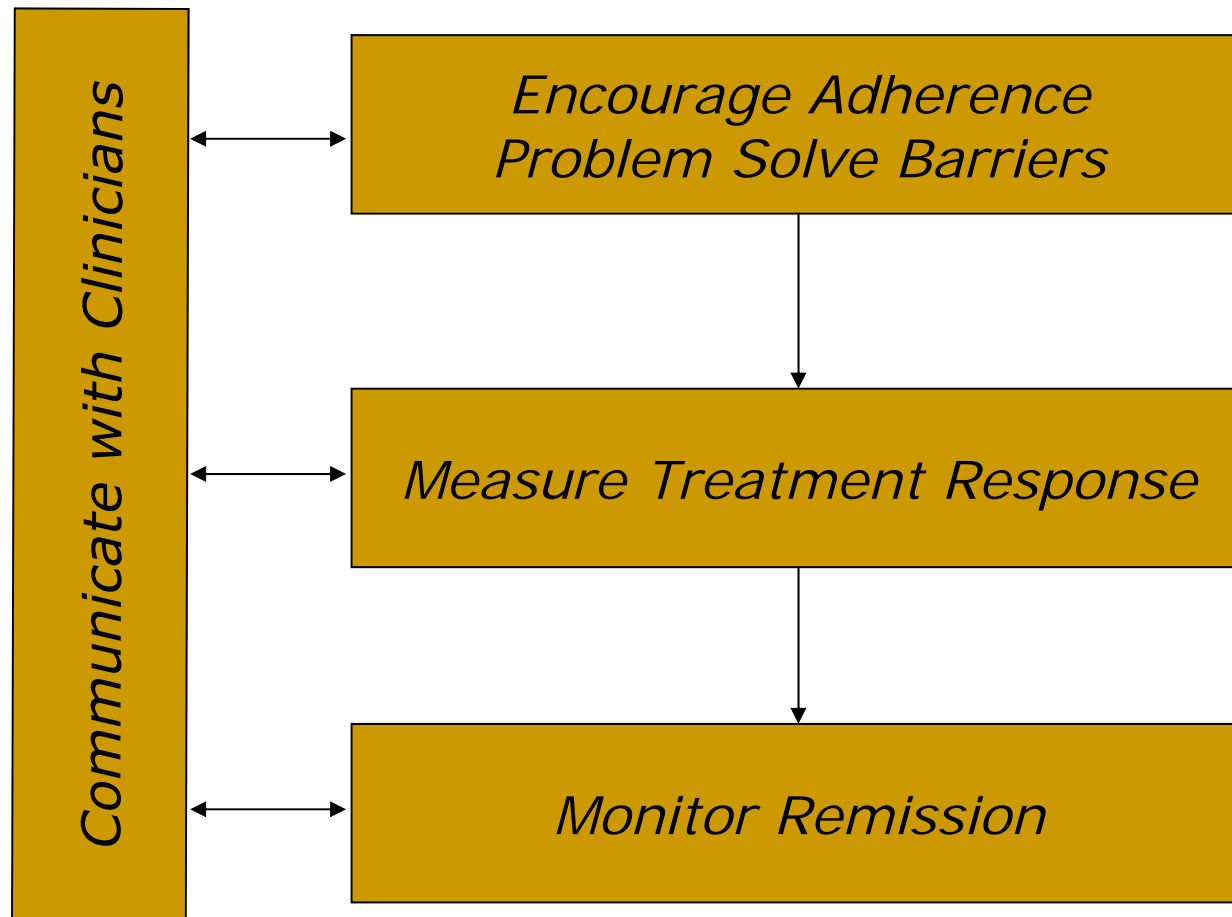
3 Component Model systems based care



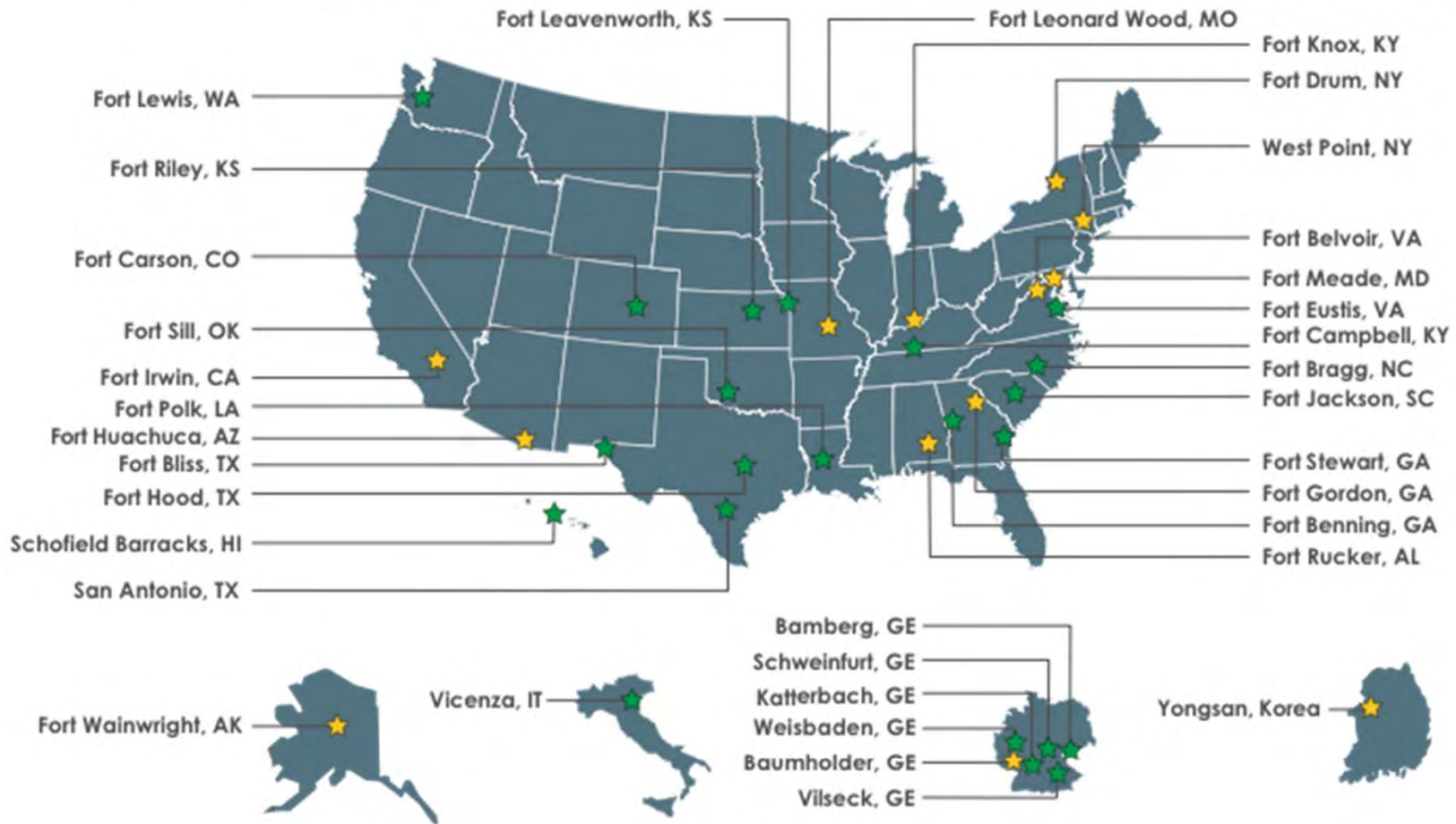
Oxman et al, Psychosomatics, 2002;43:441-450

RESPECT-Mil

Care Facilitator Functions



RESPECT-Mil Worldwide Sites



- ★ Fully Implemented Sites
- ★ Partially Implemented Sites

Levels of Implementation



- Micro: Clinic level implementation
- Meso: Site level implementation (R-SIT)
- Macro: Program level implementation (R-MIT)

RESPECT-Mil Implementation

Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- Patient education materials
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload

RESPECT-Mil Implementation

Micro- or Clinic-level



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MEDICAL RECORD - RESPECT-MII PRIMARY CARE SCREENING

For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE: _____

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen. Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE

SECTION I (Check all that apply):

Over the LAST 2 WEEKS, have you been bothered by any of the following problems?

- | | |
|---|--|
| 1. Feeling down, depressed, or hopeless. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Little interest or pleasure in doing things. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

SECTION II (Check all that apply):

Have you had any experience that was so frightening, horrible, or upsetting that IN THE PAST MONTH, you...

- | | |
|--|--|
| 3. Had any nightmares about it or thought about it when you did not want to? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Were constantly on guard, watchful, or easily startled? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Felt numb or detached from others, activities, or your surroundings? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

FOR OFFICIAL USE ONLY

PATIENT'S HEALTH QUESTIONNAIRE (Additional Comments):

Provider please reference section and question number when entering additional comments from patient.
Please sign and date entry.

RESPECT-Mil Implementation

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PTSD Instrument (PCL-C)



PCL						
Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully circle the number in the box which indicates how much you have been bothered by that problem <i>in the last month</i> . Please answer all 19 questions.						
No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1 Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2 Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	4
	3 Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
	4 Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5 Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6 Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7 Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	2	3	4
	8 Trouble remembering important parts of a stressful experience from the past?	0	1	2	3	4
	9 Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10 Feeling distant or cut off from other people?	0	1	2	3	4
	11 Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12 Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13 Trouble falling or staying asleep?	0	1	2	3	4
	14 Feeling irritable or having angry outbursts?	0	1	2	3	4
	15 Having difficulty concentrating?	0	1	2	3	4
	16 Being "super alert" or watchful on guard?	0	1	2	3	4
	17 Feeling jumpy or easily startled?	0	1	2	3	4
For Primary Care Provider - Subtotal		0	+	+	+	+
		Total = _____				
18	IF you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____Not difficult _____Somewhat difficult _____Very difficult _____Extremely difficult					
19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____Yes _____No If "Yes", how often? _____Several days _____More than half the days _____Almost everyday					

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Micro- or Clinic-level



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Participant Education & Self-Management Materials

HOW CAN YOU IMPROVE YOUR SLEEP?

Sleep problems are common for those with PTSD. Changing your sleep pattern can take at least six to eight weeks. Here are some areas where you may improve your sleep.

Avoid Caffeine: Caffeine is a stimulant found in items such as coffee, tea, soda, and chocolate, as well as in many over-the-counter medications. Those with insomnia are often sensitive to mild stimulants, and should avoid caffeine six to eight hours before bedtime. You may want to consider a trial period of avoiding caffeine altogether.

Avoid Nicotine: Some smokers claim smoking helps them to relax, but nicotine is actually a stimulant. Relaxing effects may occur when nicotine first enters the system, but as it builds up, it produces an effect similar to caffeine. Avoid smoking, dipping, or chewing tobacco before bedtime, and don't smoke to get yourself back to sleep.

Avoid Alcohol: Alcohol is a depressant. While it might help you fall asleep, as alcohol is metabolized, your sleep can become more disturbed and fragmented. Avoid alcohol after dinner, and limit its use to small or moderate quantities.

Cautiously Use Sleeping Pills: Sleep medications are effective only temporarily. If taken regularly, they lose effectiveness in about two to four weeks. Over time, sleeping pills may make sleep problems worse or lead to an insomnia "rebound." Many people, after long-term use of sleeping pills, mistakenly conclude that they need them to sleep.

Participant Brochure

Depression and Post-Traumatic Stress Disorder (PTSD)

RESPECT-Mil
(Re-Engineering Systems of Primary Care Treatment in the Military)



RESPECT-Mil
A SOLDIER'S RESOURCE FOR RELIEF AND RECOVERY

NOT ALL WOUNDS ARE VISIBLE

SELF-MANAGEMENT WORKSHEET

There are several things you can do to help yourself feel better, even when you're not at your best. Start by selecting one of the activities from this list. Plan to do it at least once a week, and then add more things as you begin to feel better.

- Make time for pleasurable physical activities.**
It's hard to make time to concentrate on your basic physical needs. One example is walking for a certain length of time each day.
For _____ days per week, I'll spend at least _____ minutes doing _____.
- Find time for pleasurable activities.**
Even though you may not feel as motivated or happy as you used to, commit to scheduling a fun activity (such as a favorite hobby) at least a few times a week.
For _____ days per week, I'll spend at least _____ minutes doing _____ (be sure to make your goal both easy and reasonable).
- Spend time with people who can support you.**
It's easy to feel isolated when you're feeling down, but it's almost like there's a switch that turns off your support system. If you can, explain to them what you are going through. If you don't feel comfortable talking about it, then just sit with them. Just being with them can be helpful. During one of your visits, a good first step is to go to the gym, go to the library, or go to a support group. (A good first step is to go to the gym, go to the library, or go to a support group.)
During the next week, I'll make contact at least _____ times with _____ (name) doing/doing about _____.
- Practice relaxing.**
For many people, the changes that come with depression or PTSD can lead to anxiety. Stress physical activities can lead to mental relaxation, possibly in taking a break. Try deep breathing, taking a warm bath, or just taking a quiet, comfortable, peaceful place. Some things that you can do to relax are:
For _____ days per week, I'll do a physical relaxation activity _____ times, for at least _____ minutes each time. (Be sure to make your goal both easy and reasonable.)
- Simple goals and small steps.**
It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others can't. It can be helpful to deal with them when you're feeling better. Here are some small steps you can take to deal with them when you're feeling better. Try taking down large problems in smaller pieces and then take one small step at a time. Give yourself credit for each step you accomplish.
The problem is: _____
My goal is: _____
Step 1: _____
Step 2: _____
Step 3: _____
- Get nutritious, balanced meals.**
You are what you eat. Many people find that when they eat more nutritious, balanced meals, they feel better physically, they feel better emotionally, and they feel better.
During the next week, I will improve my diet by: _____ (Example: "I will eat at least two fruits and vegetables a day.")
- Avoid or minimize alcohol use.**
Alcohol is a depressant and can add to feeling down and alone. It can also interfere with the help you may receive from antidepressant medication.
I will limit my alcohol intake to no more than two drinks or no more than two days per week.

Goals & Self-Management Worksheet

RESPECT-Mil Depression Management Using the PHQ-9 (0-27 point scale)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Sometimes	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having less energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure, or guilt	0	1	2	3
g. Trouble concentrating on things, such as reading, watching TV, or listening to the radio	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been noticed	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total Score: _____

2. If you checked off any problems, how difficult have these problems made it for you to do your work?

	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
a. Your work	0	1	2	3
b. Your daily activities	0	1	2	3

PHQ-9 Score: _____

Depression Severity Scale:

PHQ-9 Score	Depression Severity	Provisional Diagnosis	Treatment Recommendations
0-4	No Depression	N/A	N/A
5-9	Minimal Symptom*	Major Depressive Disorder, Single Episode	Support, educate, call if worse, return in one month.
10-14	Moderate Symptom**	Major Depressive Disorder, Recurrent Episode	Support, watchful waiting, Antidepressant or counseling.
15-19	Severe Symptom***	Major Depressive Disorder, Severe	Antidepressant or counseling.
20-27	Very Severe Symptom****	Major Depressive Disorder, Very Severe	Antidepressant and counseling.

Initial Response to an Adequate Dose of Antidepressant After Six - Eight Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of 5 points from baseline	Adequate	No treatment change needed. Case Facilitator follow-up in four weeks.
Drop of 3-4 points from baseline	Probably inadequate	Probably warrants an increase in dose.
Drop of 1-2 points or no change or increase	Inadequate	Increase dose, switch drugs, augmentation, or formal psychiatric consultation. Add counseling.

Initial Response to Counseling After Four Sessions over Six Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of 5 points from baseline	Adequate	No treatment change needed. Case Facilitator follow-up in four weeks.
Drop of 3-4 points from baseline	Probably inadequate	Probably no treatment change needed. Share PHQ-9 with the provider.
Drop of 1-2 points or no change or increase	Inadequate	If depression-specific psychological counseling (CBT, PBO, ACT, etc.) is available, consider adding to treatment. For patients, consider other types of psychological counseling, consider starting antidepressant, review treatment options and preferences.

PHQ-9 Copyright © 2002 by the Medical Outcomes Trust. All rights reserved. Reproduction in full or in part is permitted for non-commercial use only. For more information, visit <http://www.phq-patient.com/terms>.

* If symptoms persist or worsen, your provider should consider antidepressant treatment. ** If symptoms persist or worsen, your provider should consider antidepressant treatment. *** If symptoms persist or worsen, your provider should consider antidepressant treatment. **** If symptoms persist or worsen, your provider should consider antidepressant treatment.

Provider "Fast Facts"

RESPECT-Mil Implementation

Micro- or Clinic-level



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DESTRESS-PC



- **DE**livery of
- **Self-**
- **TR**aining &
- **E**ducation for
- **S**tressful
- **S**ituations –
- **P**rimary **C**are version

*Web-based, nurse assisted,
CBT-based PTSD self-training*

Article

A Randomized, Controlled Proof-of-Concept Trial of an Internet-Based, Therapist-Assisted Self-Management Treatment for Posttraumatic Stress Disorder

Brett T. Litz, Ph.D.

Charles C. Engel, M.D., M.P.H.

Richard Bryant, Ph.D.

Anthony Papa, Ph.D.

Objective: The authors report an 8-week, randomized, controlled proof-of-concept trial of a new therapist-assisted, Internet-based, self-management cognitive behavior therapy versus Internet-based supportive counseling for posttraumatic stress disorder (PTSD).

Method: Service members with PTSD from the attack on the Pentagon on September 11th or the Iraq War were randomly assigned to self-management cognitive behavior therapy (N=24) or supportive counseling (N=21).

Results: The dropout rate was similar to regular cognitive behavior therapy (30%) and unrelated to treatment arm. In the

intent-to-treat group, self-management cognitive behavior therapy led to sharper declines in daily log-on ratings of PTSD symptoms and global depression. In the completer group, self-management cognitive behavior therapy led to greater reductions in PTSD, depression, and anxiety scores at 6 months. One-third of those who completed self-management cognitive behavior therapy achieved high-end state functioning at 6 months.

Conclusions: Self-management cognitive behavior therapy may be a way of delivering effective treatment to large numbers with unmet needs and barriers to care.

(Am J Psychiatry 2007; 164:1–8)



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FIRST-STEPS

Web-based Care-Manager Support & Reporting System

The screenshots illustrate the PBRMS (Patient-Based Reporting and Monitoring System) interface, which is a web-based care-manager support and reporting system. The interface is divided into several sections: a top navigation bar, a left sidebar with a 'PRE Work Flow' menu, and a main content area.

Top Navigation Bar: Includes links for Home, Resources, Contact, Help, Logout, and a PBRMS logo. It also features a search bar and a 'New Individual' link.

Left Sidebar (PRE Work Flow): Contains a vertical menu with options: Collect Information, General Concern, Medication Non-Adherence, Counseling Non-Adherence, Self Management Concern, PHQ-9, Case Status, Estimate, Snapshot Estimate, Management, Contact Information, Scheduling, Medication, Counseling, and Management Plan.

Medication Management Screenshot (Top Left): Shows the 'Medication' section for 'Larry Gracen'. It includes a 'New Entry' form with fields for Medication (Ambien®), Dose (50 mg), Prescribe Date (10/15/2008), Change Date (10/18/2008), Change Type (Start Med), and Comments (Todd Musig (30 Oct 08)). A 'Save' button is present.

Summary Screenshot (Bottom Left): Displays a 'SUMMARY FOR:' section for 'Larry Gracen'. It shows 'Episodes' (1 New Episode) and 'Snapshots' (2 Selected Episodes). The 'Episodes' section indicates 'Episode is OPEN and waiting for input.' The 'Snapshots' section shows two snapshots with their respective PHQ-9 and PCL scores.

Final Estimate Screenshot (Top Right): Shows the 'FINAL ESTIMATE FOR:' section for 'Jane Smithe'. It displays a table of estimates for various categories (General Concern, Medication Non-Adherence, Counseling Non-Adherence, Self Management Concern, PCL, Suicide Staffing, Case Status) across three time points: First, Previous, and Current. The table uses color-coded bars to represent the level of concern (Low, Moderate, High).

Legend: A color-coded legend at the bottom right indicates the level of concern: Low (Green), Moderate (Yellow), and High (Red).

Category	First	Previous	Current
General Concern	Moderate	Low	Low
Medication Non-Adherence	High	High	Moderate
Counseling Non-Adherence	High	Moderate	Low
Self Management Concern	Low	Moderate	High
PCL	33-55	13-32	13-32
Suicide Staffing	A Week	A Week	N/A
Case Status	Flagged	No Flag	No Flag

Based on the information obtained from the above Factor Groups, please rate the level of concern you have for this patient.

Low Moderate High

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- **Weekly BH Champion review of facilitator caseload**

FIRST-STEPS

Improves Efficiency, Accountability & Effectiveness of Facilitator Staffing



Home	Resources	Contact	Help	Logout	PBRMS		
Select Individual >	Open/Recent PREs	A B C D E F G H I J K L M N O P Q R S T U V W X Y Z ALL				Search	New Individual
Acuity			IMPORTANT MESSAGE		MESSAGE FROM PREVIDENCE		
			Welcome.		Welcome to the Previdence Risk		
					more		
Acuity	Case Closure	Call Schedule	Caseload	Closed Cases			
MY VIEW UNIT VIEW					Print Preview		
Unit	Name	Suicide Staffing	Facilitator Concern	Deployers	Tx Non-Response	Last Staffing Date	Last Contact
Fort Hood	April, Test	Unknown	Moderate	30-80 Days	No		25 Apr 08
Germany 1	Braxton, Bruce	Emergency	High		No		12 Aug 08
Beta Fort Stewart	Frankie, Bill	A Duty Day	High	60-90 Days	No	2 Oct 08	2 Oct 08
Beta Fort Bliss	Harry, Dirty	A Duty Day	High	Not Deploying	No		20 Oct 08
Fort Drum	New, Tom	A Duty Day	Unknown		No		24 Apr 07
Fort Carson	Turner, Bill	A Duty Day	Unknown		No		20 Apr 07
Vicenza	Violet, Eric	A Duty Day	Unknown		No		19 Apr 07
Fort Lewis	Wilking, Sarah	A Duty Day	Unknown		No		19 Apr 07

RESPECT-Mil Implementation

Macro- or Program-level



RESPECT-Mil Implementation Team (R-MIT):

- Monitors program implementation, fidelity, outcomes
- Trains & consults with R-SiTs
- Develops & disseminates education modules and tools
- Pilots & evaluates new components
- Performs site visits & site calls

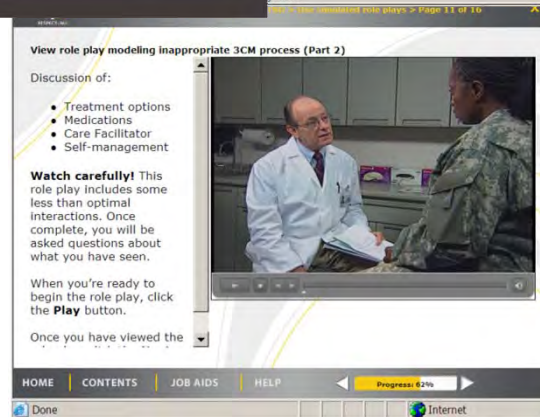
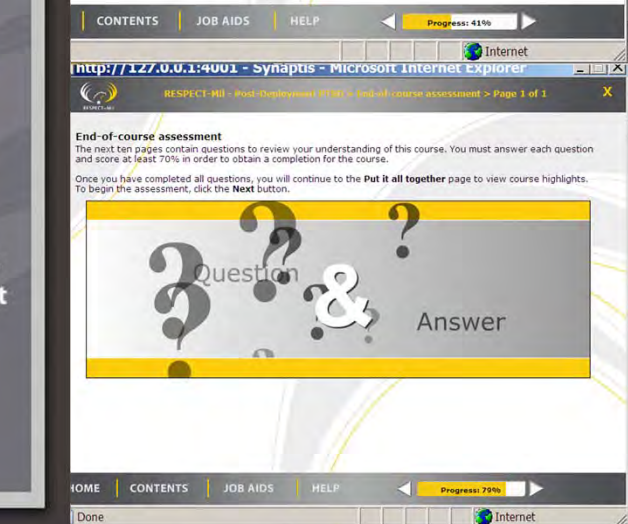
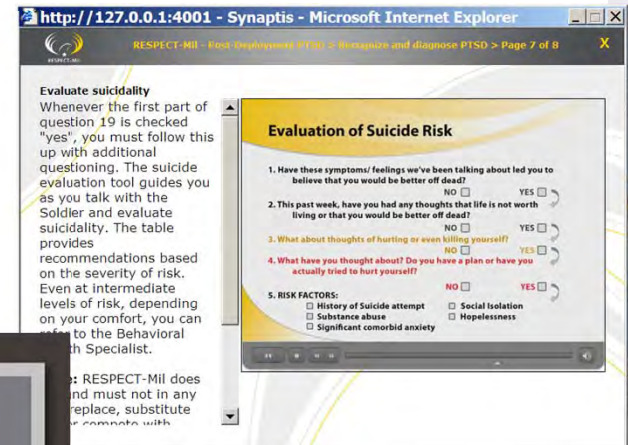
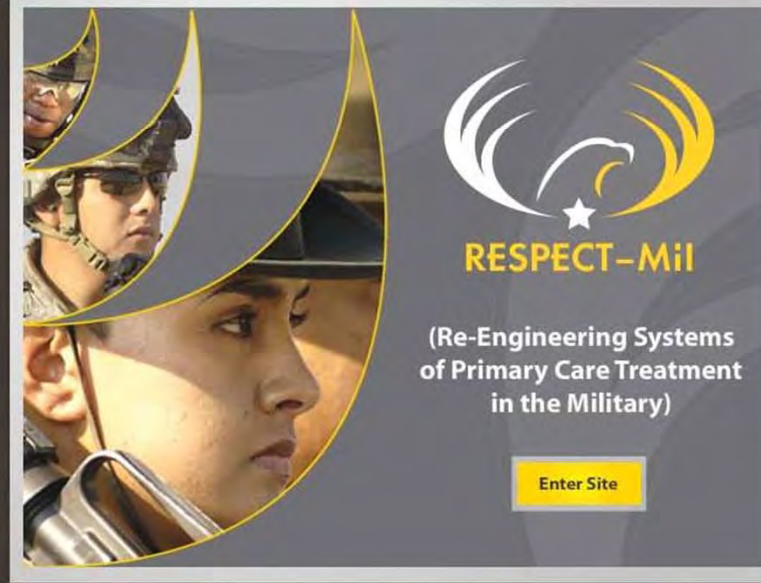
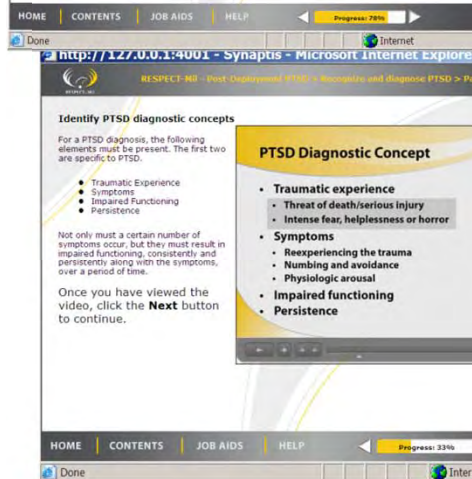
RESPECT-Mil Implementation

Meso- or Site-level



- RESPECT-Mil Site Team (R-SIT)
- Primary Care Champion
 - Monitors local program & process
- Behavioral Health Champion
 - Monitors facilitator caseloads
- Facilitator
 - RN, 1 per 6K in eligible population
- Administrative assistant
 - 1 per 10K in eligible population

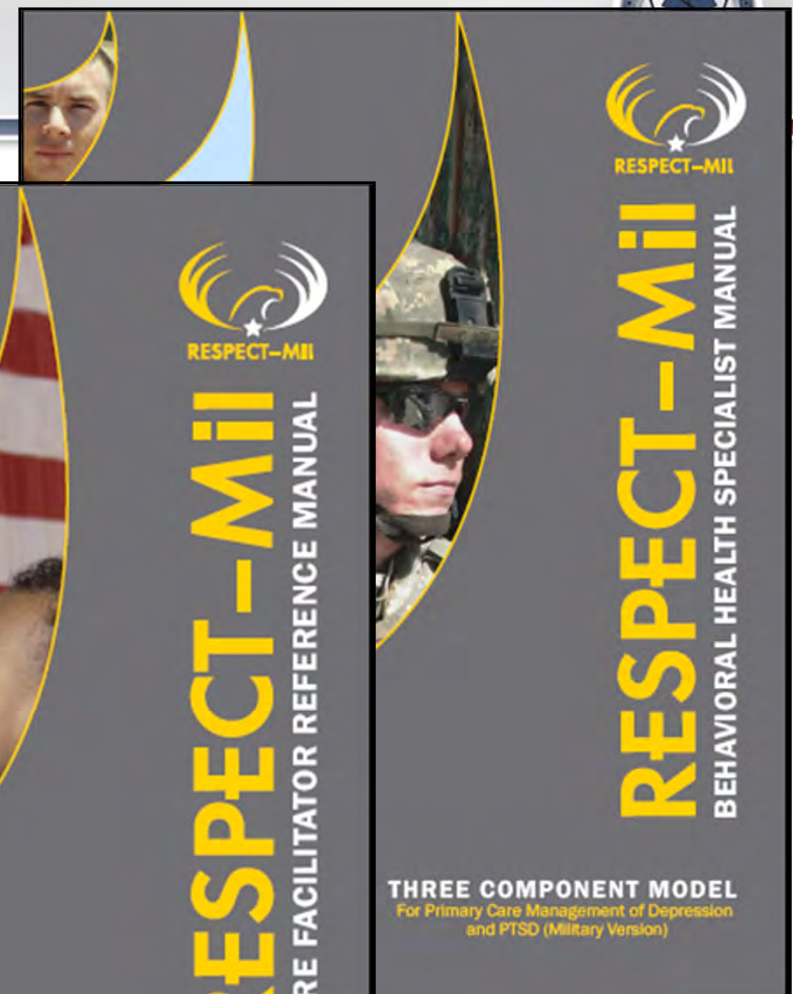
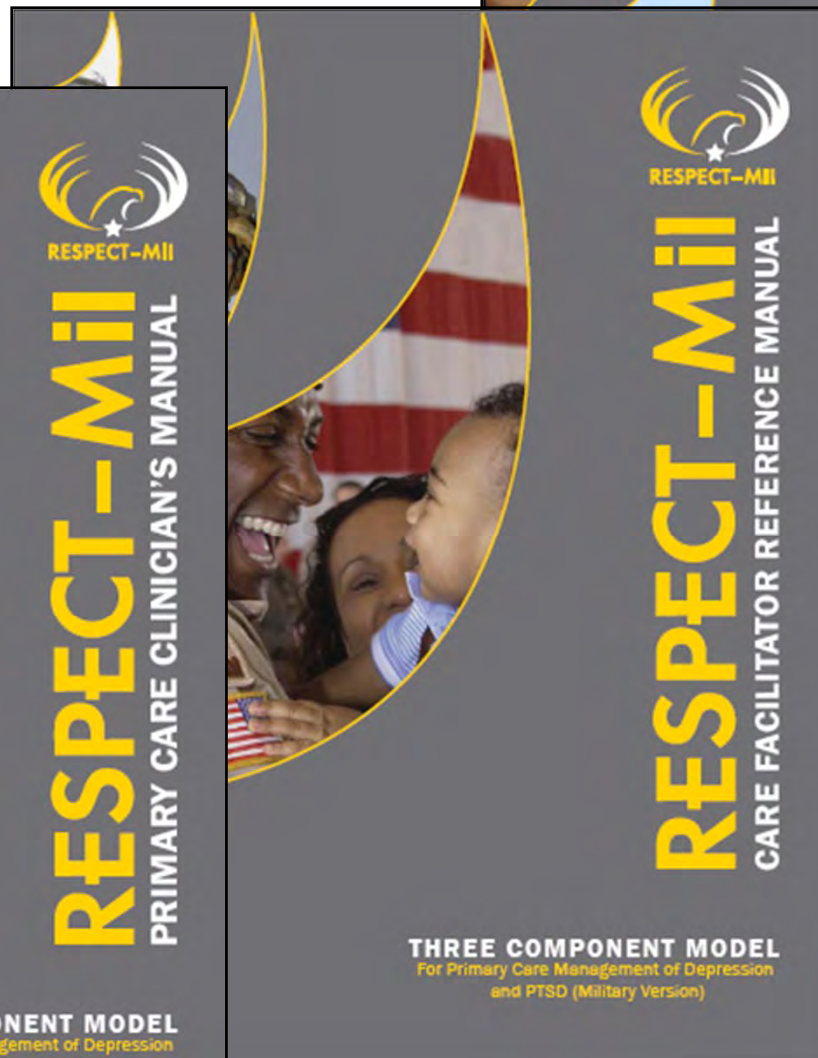
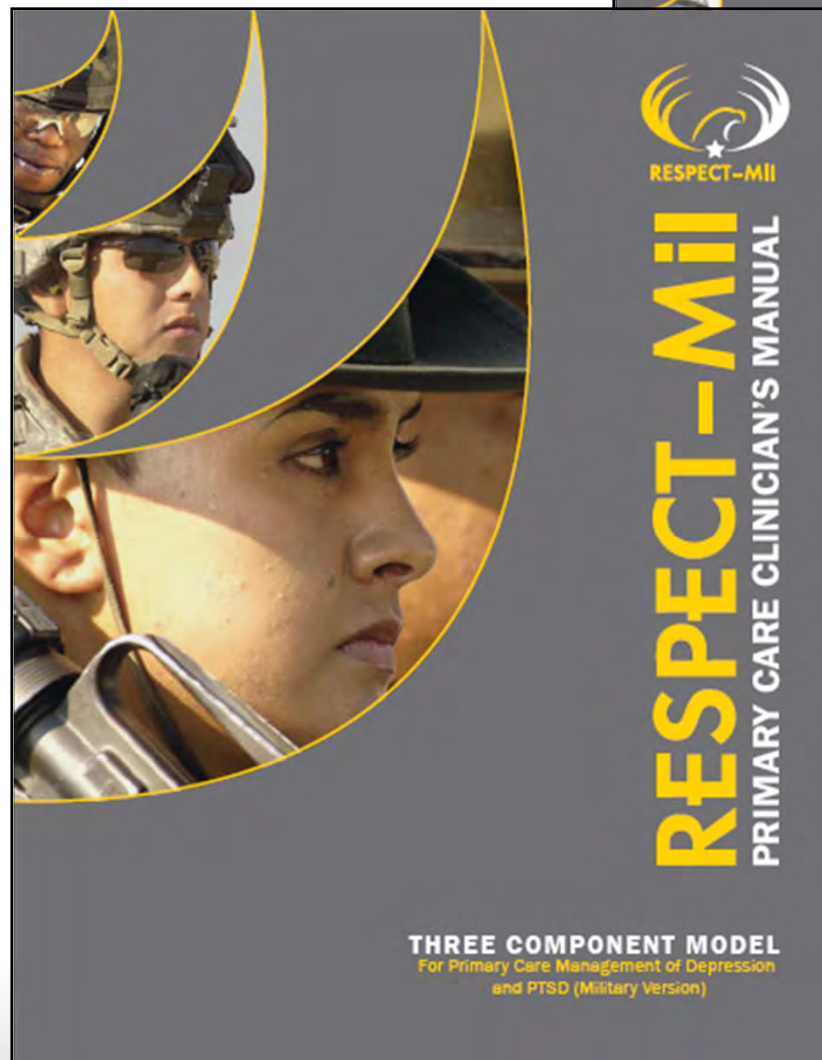
Web-Based PTSD & Depression Training for Primary Care Providers*



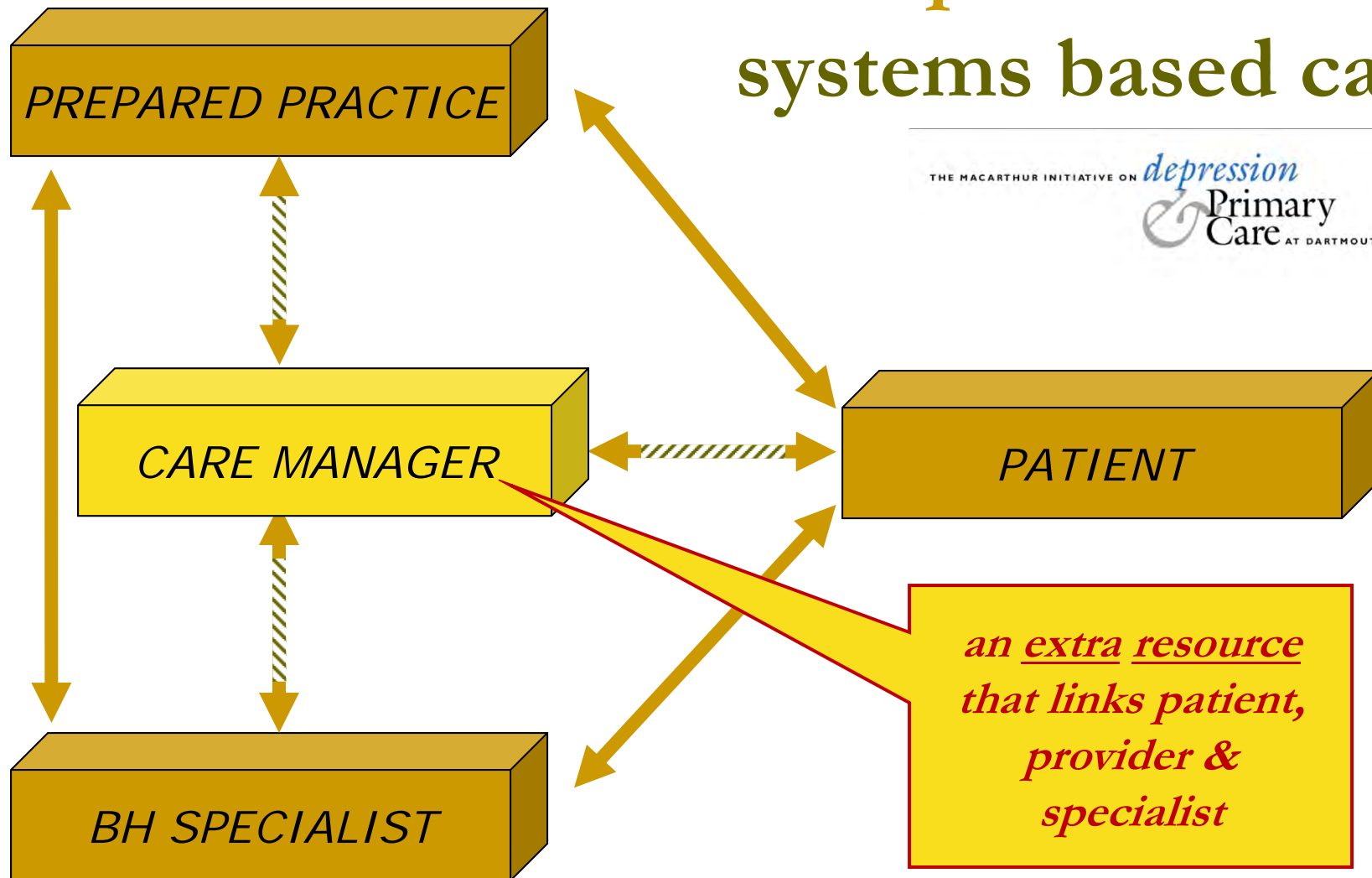
* Includes suicide assessment training

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Provider Manuals



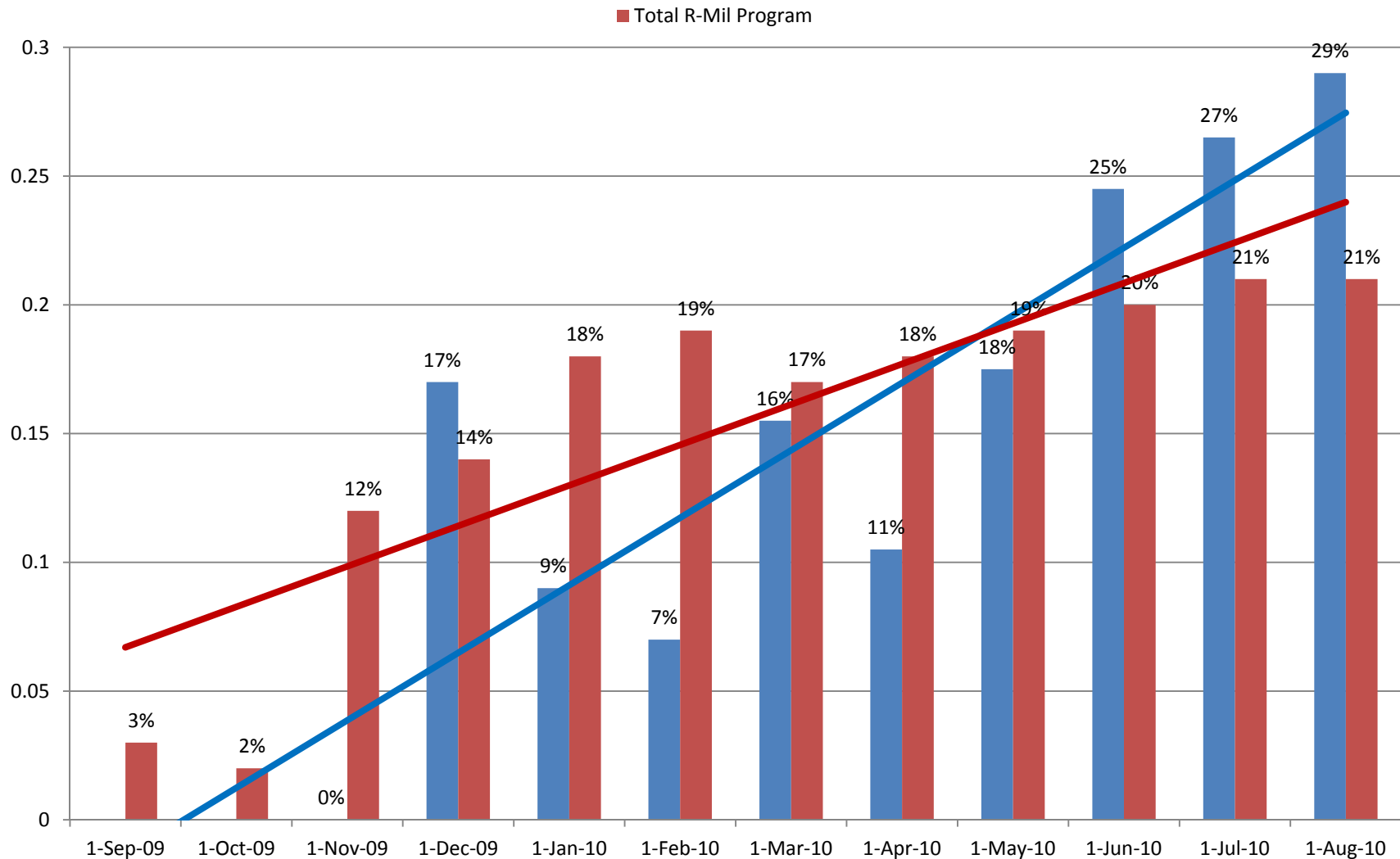
3 Component Model systems based care



Oxman et al, Psychosomatics, 2002;43:441-450

Real-time Aggregate Data Reports

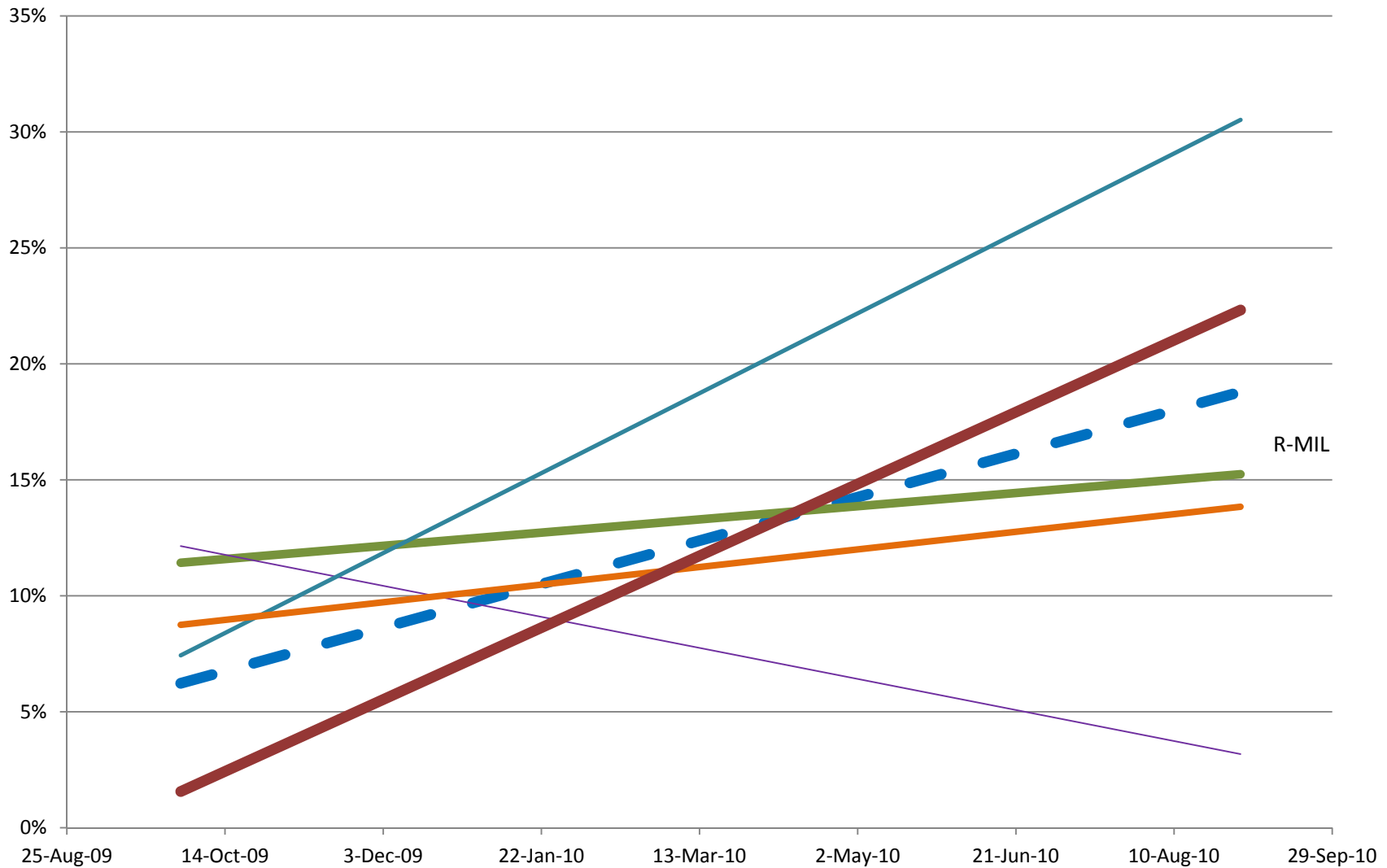
Region PTSD Remission Trend



**Remission is defined as the count of individuals who have an open episode in FIRST STEPS, have been in the system 8 weeks or more, and have a PCL score of 10 or less.

Real-time Aggregate Data Reports

PTSD Remission Trends by Region



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Implementation Results

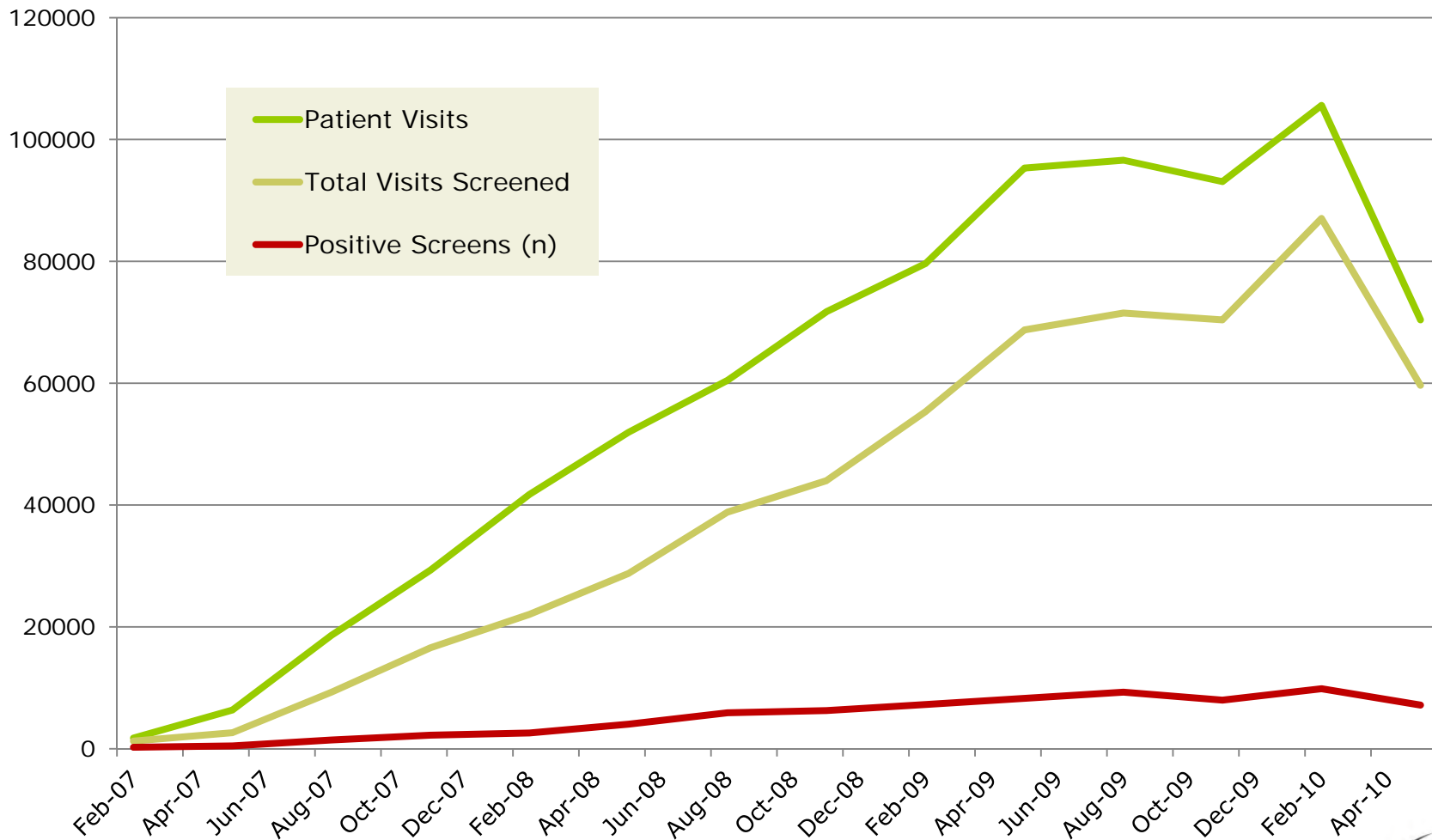


- **55** clinics now implementing (95 projected)
- **84%** of visits screened (versus 2-5% in non-RESPECT-Mil teaching clinic)
- **13%** of all screened visits are positive
- **48%** of positive screens result in a diagnosis of 'depression' or 'possible PTSD'

** Data through November 2010*

RESPECT-Mil Screening Visits

Consistently Rising Rate of Program Implementation



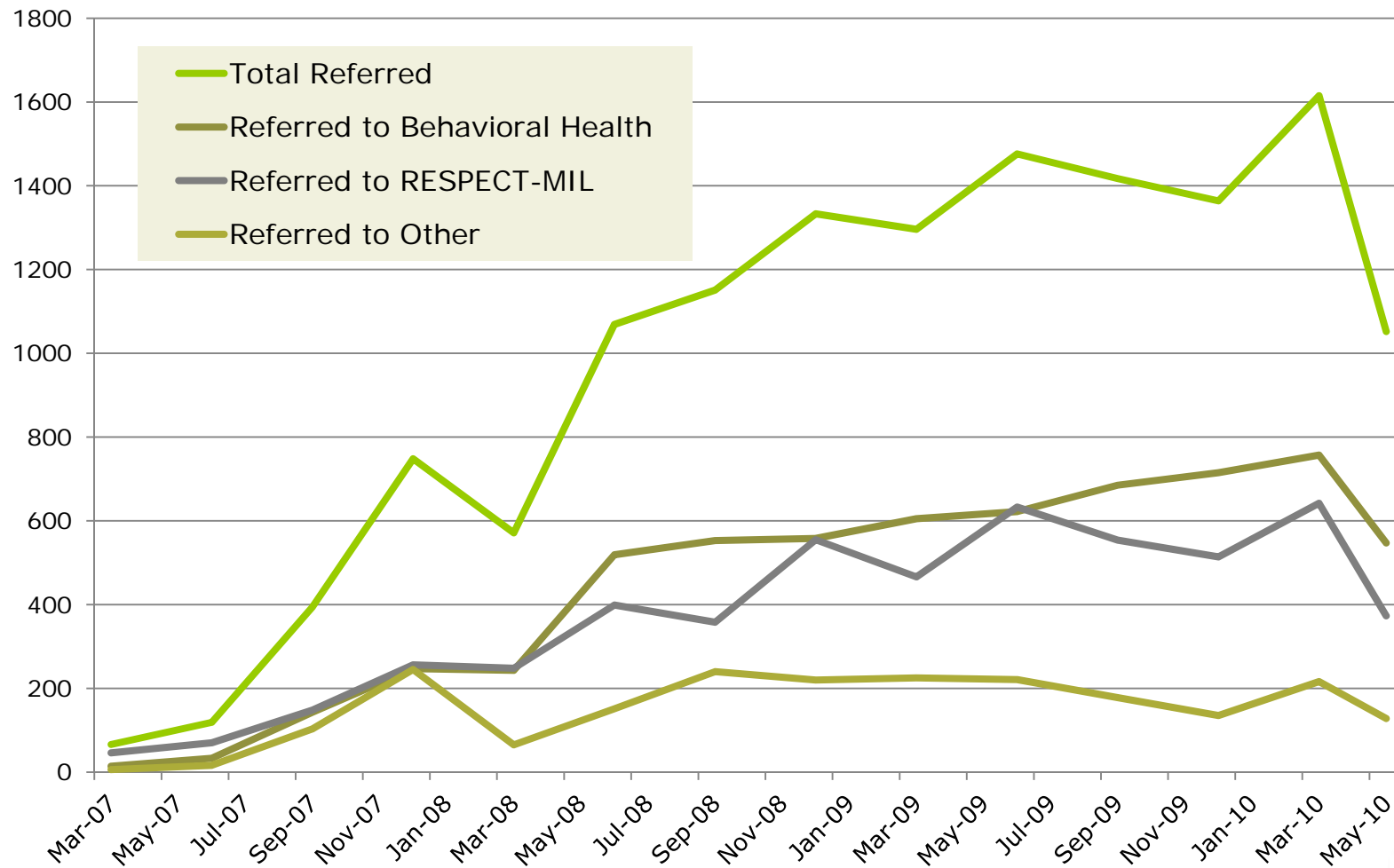
Data through May 2010

32



Referrals for Enhanced BH Services

Referrals for Facilitation Nearly as High as to Specialist

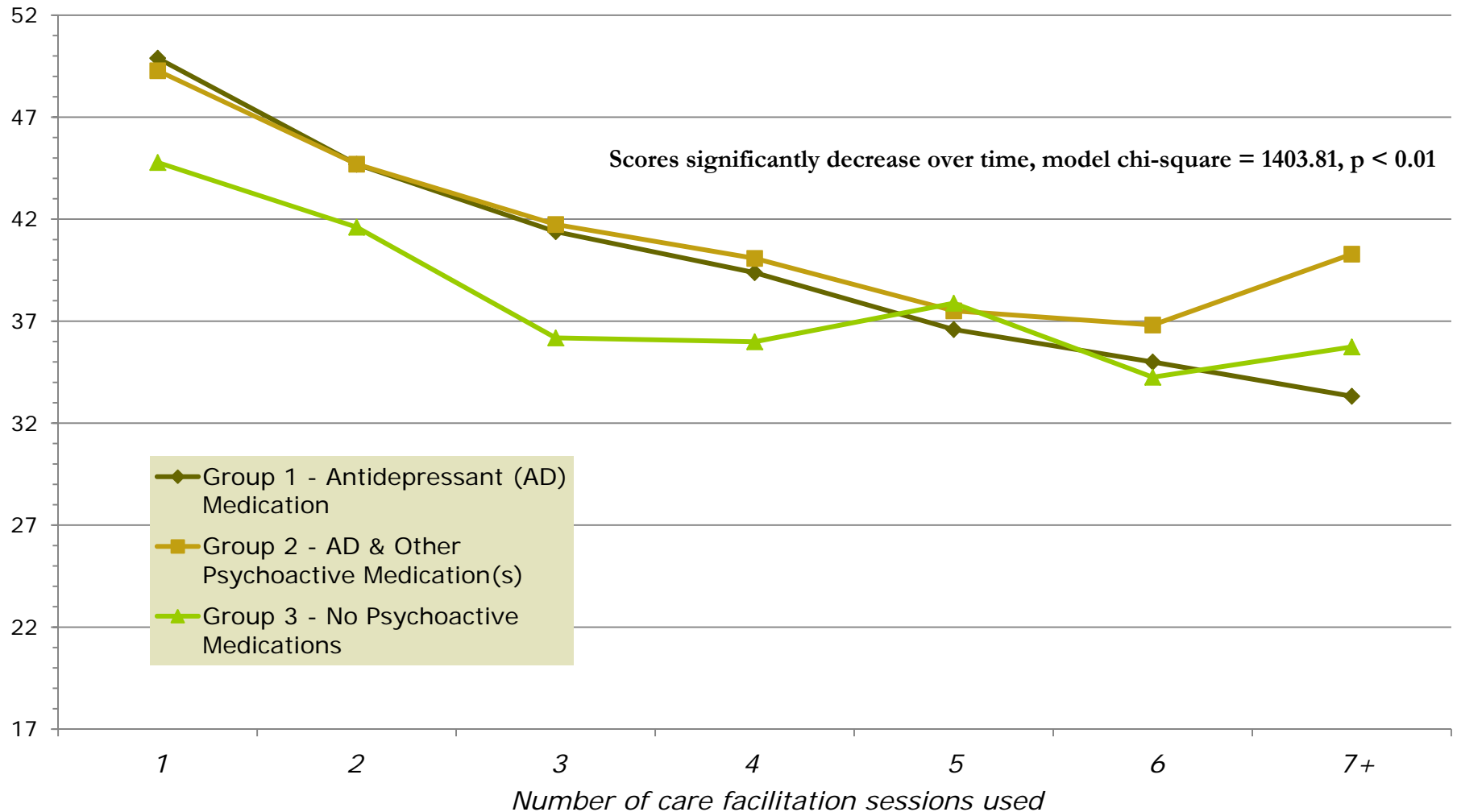


** Data through May 2010*

33

Care Facilitation & PTSD Severity (PCL-C)

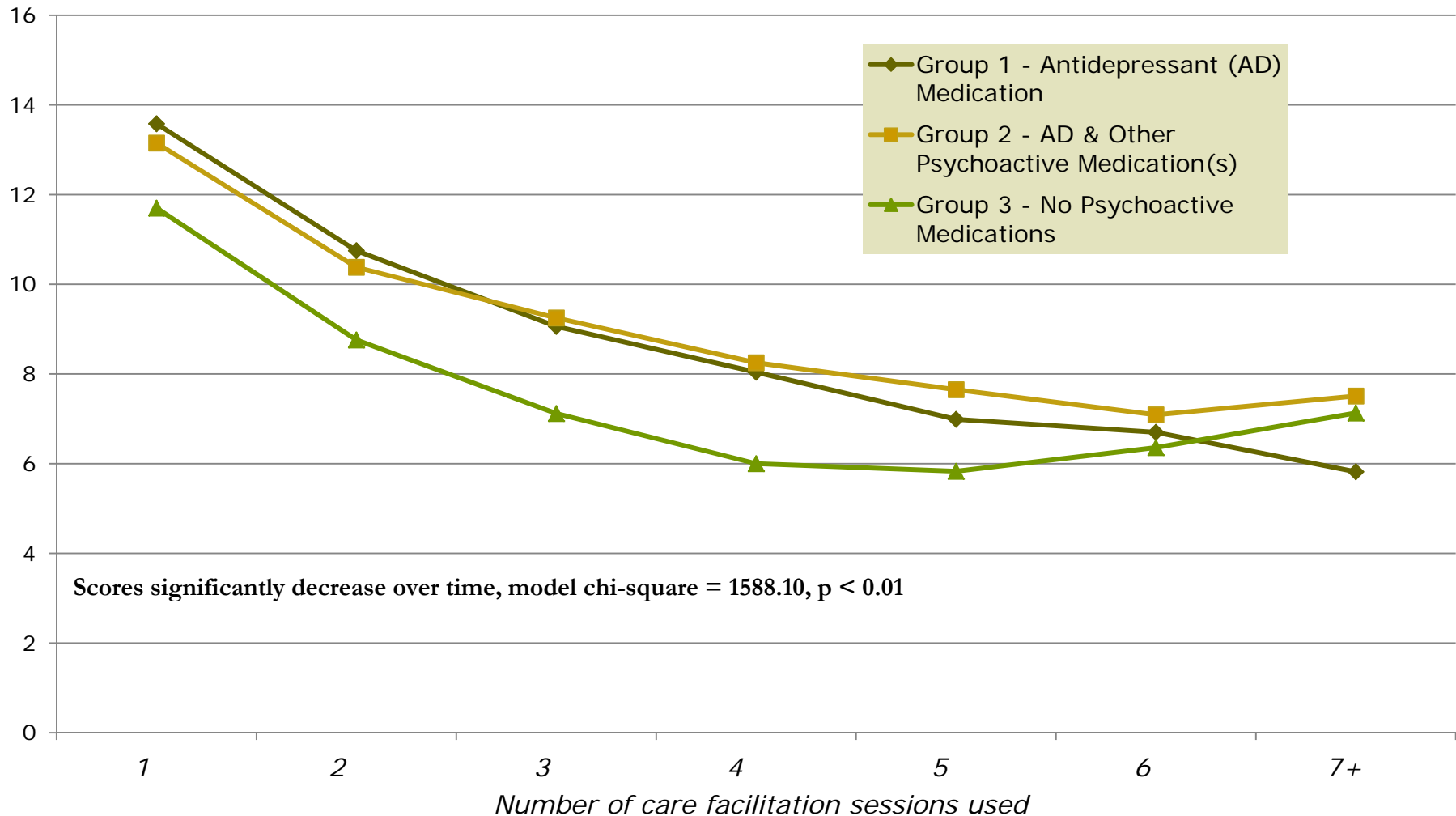
Number of facilitator visits associated with improvement



* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

Care Facilitation & Depression Severity (PHQ-9)

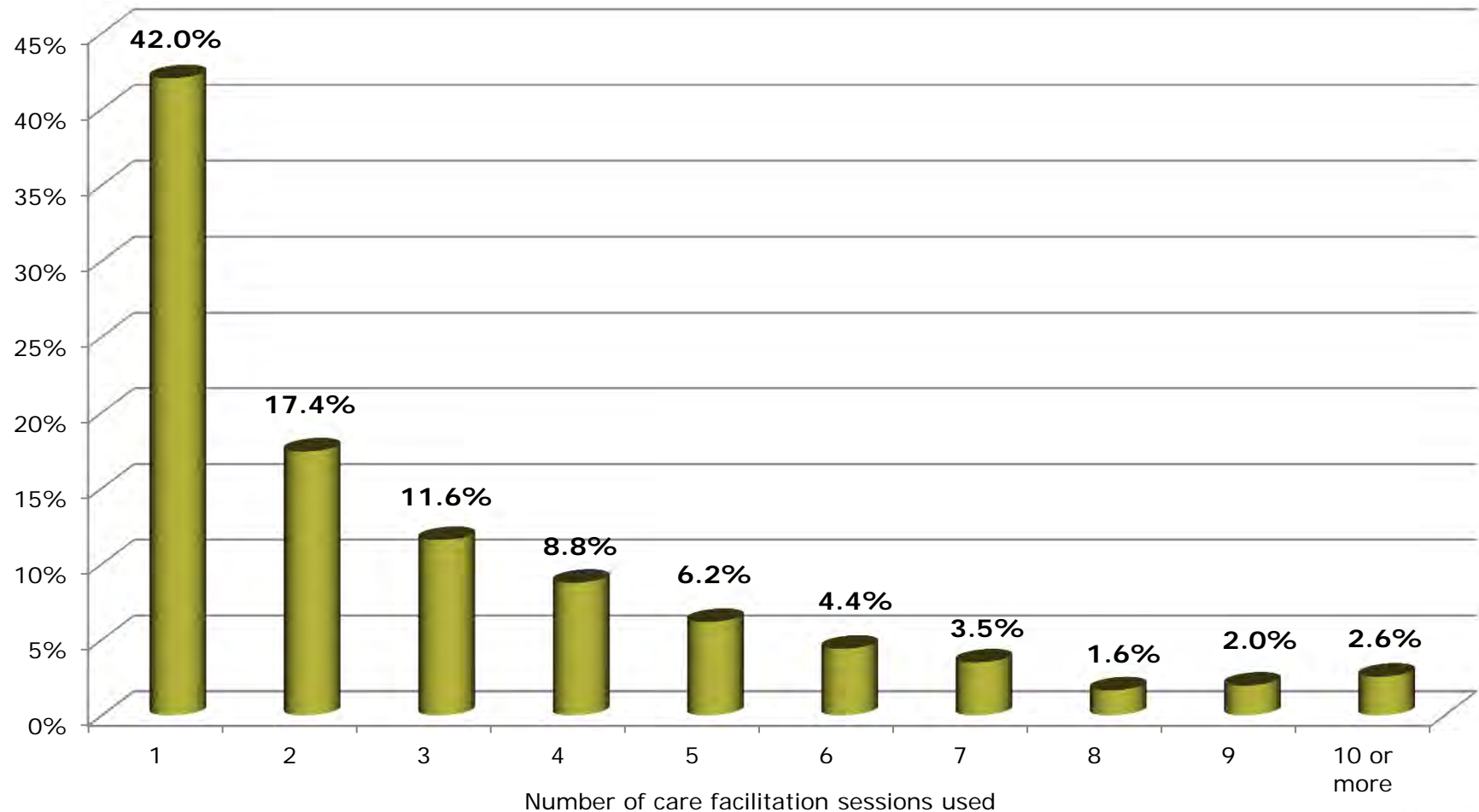
Number of facilitator visits associated with improvement



* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

RESPECT-Mil Facilitator Use

Only 20.6% have four or more facilitator contacts



* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

RESPECT-Mil

Safety & Risk Management



- Visits associated with any suicidal ideation
- 1% of screened visits (7.6% of screen positive visits)
- 27% of visits involving suicidal ideation are rated by provider as intermediate or high risk (“non-low risk”)
- Frequent “save” anecdotes

** Data through Nov 2010*

RESPECT-Mil

Safety & Risk Management



- Visits associated with any suicidal ideation
- Appropriate risk assessment
 - 99.4% of screened positive visits
- Appropriate risk assessment
 - 99.9% of screened visits

** Data through May2010*

RESPECT-Mil

Dispositions



66% assistance rate
accept/[accept + decline]

3% of all visits
involve recognition & assistance for
previously unrecognized mental health needs

** Data through Nov 2010*

RESPECT-Mil

Findings to Date



- Often concerns about getting started
- Once started, approach is acceptable and feasible for both Soldiers and providers
- Enrolled soldiers show clinical improvement
- Identifying & referring Soldiers with previously unrecognized and unmet needs
- Enhanced safety and risk assessment capabilities

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Challenges & Road Ahead



- Intercalation with **Patient Centered Medical Home**
- Web-based training ongoing
<http://www.pdhealth.mil/respect-mil.asp>
- **FIRST-STEPS** performance reporting
- **Alcohol SBIRT** demonstration in preparation
- **REHIP** triservice demonstration of a “blended” model
- **STEPS-UP Trial** – a 5-year, 18-clinic controlled trial (n=1500) intervention is blended + centralized care management + stepped psychosocial modalities

RESPECT-Mil

Review of Findings to Date



- Often concerns about getting started; once started the approach is feasible and acceptable
- Identifying & referring patients with previously unrecognized and unmet needs
- Clinical improvement is related to use of care facilitation
- Only ~20% reach 4 facilitator visits (~5 months)
- Most sites lack accessible evidence-based psychosocial therapies

RESPECT-Mil Central

Implementation Team

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Durham VA

Kurt Kroenke, MD

Professor of Medicine, Indiana University &
Regenstrief Institute





National Academy Press. 1999; pp. 173-212
Population and Need-Based Prevention of Unexplained Physical Symptoms in the Community

Charles C. Engel, and Wayne J. Katon



PHILOSOPHICAL
TRANSACTIONS
OF
THE ROYAL
SOCIETY

Maintaining future war syndromes: international perspectives and new models of care

Charles C. Engel^{1,2,3,4}, Kenneth C. Hyams³ and Ken Scott⁴

Population-based health care: A model for restoring community health and productivity following terrorist attack

Charles C. Engel, Ambereen Jaffer, Joyce Adkins, Vivian Sheliga, David Cowan, and Wayne J. Katon

Terrorism and Disaster

Individual and Community Mental Health Interventions

Robert J. Ursano

Carol S. Fullerton

Ann E. Norwood

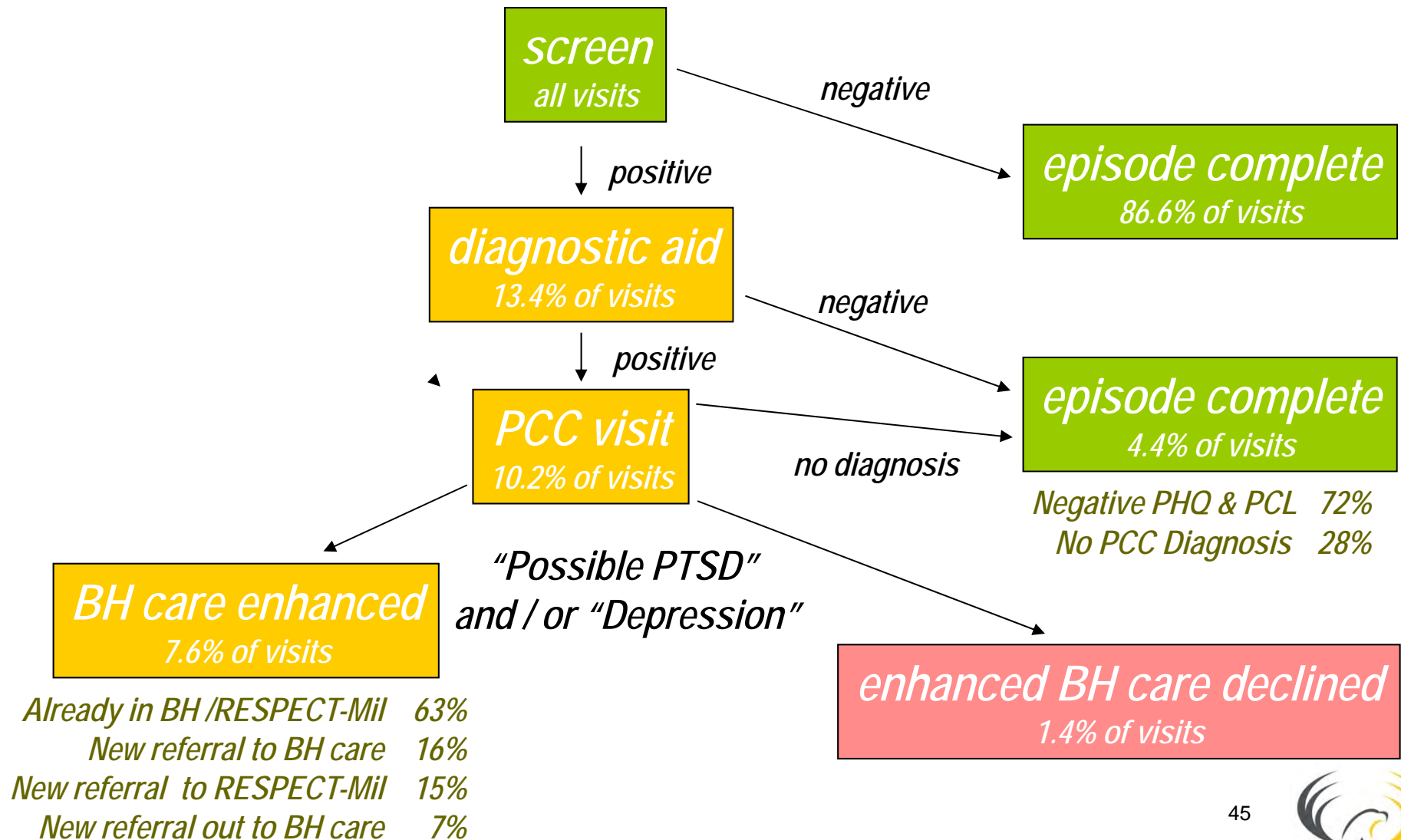
Can We Prevent a Second 'Gulf War Syndrome'? Population-Based Health Care for Chronic Idiopathic Pain and Fatigue after War¹

Charles C. Engel^{a,b}, Ambereen Jaffer^b, Joyce Adkins^b, James R. Riddle^c, Roger Gibson^d

Advances in Psychosomatic Medicine 2004;25:102-22

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Patient Flow & Clinic Process



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Time & Workload

<u>component</u>	<u>% visits</u>	<u>estimated time / visit</u>
<i>All clinic patients</i>	<i>100.0%</i>	<i>2 minutes medic time</i>
<i>Screen positive</i>	<i>13.4%</i>	<i>3 minutes medic time</i>
<i>Diagnosis</i>	<i>10.2%</i>	<i>10 minutes clinician time</i>
<i>Suicidality</i>	<i>0.7%</i>	<i>25 minutes clinician time</i>

Total Estimated Time Per Visit

$$\text{Medic} = 2 + (0.134 \times 3) = 2.4 \text{ min}$$

$$\text{Provider} = (0.102 \times 10) + (0.007 \times 25) = 1.2 \text{ min}$$

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Creating Efficiencies

- ~ 90% of visits require **NO** added provider **time**
- ~ **84%** of added clinician time is for the **0.7%** of visits at highest risk

